Request For Proposal - 100+ Eligible Employees

Broker Name:	
Agency/Firm Name:	
Street Address:	
Broker of Record:	

Group Information				
Company Name:				
Street Address:				
Nature of Business / SIC:				
Years in Business:				
Total # of Eligible Employees:				
Total # of COBRA Employees:				
Employer Contribution:				
Waiting Period:				
Effective Date requested:				
Proposal Deadline:				
Lines of Coverage Requested:	Medical	Dental	Vision	Life/AD&D

Current Rates					
Carrier	Plan	EE Only	EE+SP	EE+CH	Family

Renewal Rates					
Carrier	Plan	EE Only	EE+SP	EE+CH	Family

Current Benefits					
HMO					
Plan Name	Copay	Deductible	Hospital	Coinsurance	Rx
PPO					
Plan Name	Copay	Deductible	Hospital	Coinsurance	Rx

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Does the group provide any reimbursement for copays?	Yes	No

Additional Group Coverage Information		
Plan	**Carrier**	**Plan Design**
Dental		
Vision		
Life		
LTD		

Known health conditions, pregnancies, disabilities, and/or claims over $15,000?			
Date	**Diagnosis**	**Prognosis**	**Known ongoing treatment**

Five year Carrier History	
Carrier	**Year**

Census: Please provide census data with Age or DOB, Gender, Dependent Status, Employee Zip Code, Medical Plan Enrollment, and Dental Plan Enrollment.
A template is available at rbgsocal.com

Comments